

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

04161

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Fruitland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charles C. Ball

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MW

Married

6. (b) Name of husband or wife

Bertha Ball6. (c) If alive, give age 70 years

7. Birth date of deceased (mo. day, yr.)

Sept. 24 1864

8. AGE:

Years 81Months 6Days 1

If less than one day

hrs. .... min.

9. Birthplace

Fruitland (Town, county and state) md.

10. Usual occupation

Farmer

11. Industry or business

William Ball

12. Name

Fruitland, md

13. Birthplace

Elyabek Livingston

14. Maiden name

Fruitland, md

15. Birthplace

Fruitland, md

16. Informant

Mrs. Elton Ball

Address

Fruitland, md

17. Burial

Date thereof April 29 1946

(Burial, cremation, or removal. Which?)

(Month) (day) (year)

Cemetery or crematory

Friendship Cemetery

Location

Cast Prince Anne

18. Funeral director

Charles Darrell

Address

Princess Anne, md19. 4/27/46 (Date rec'd by registrar)19. 4/27/46 (Date signed)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Fruitland (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1946

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

19.

19.

end that I last saw h..... alive on

19.

Immediate cause of death

Hypertensive cardio-  
vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

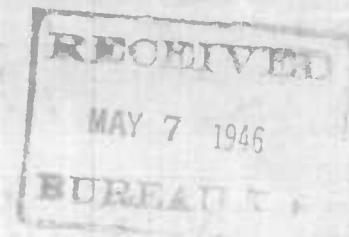
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Lee L. Lawrence, M.D. M. D. or otherAddress Princess Anne, md Date signed 4-27



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Cohen

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14

04162

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Solomons

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

3 days

## 3. (a) FULL NAME

Ballard Barbara Ann

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan (1) 1941 (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Year 10 Month no Days 10 mo. If less than one day

## 9. Birthplace

Stockton (Town, county, and state) md, Wooton

## 10. Usual occupation

## 11. Industry or business

12. Name artie Ballard13. Birthplace Stockton md14. Maiden name Emma Wallup15. Birthplace Baltimore md16. Informant artie BallardAddress Stockton md17. Burial (Burial, cremation, or removal. Which?)Date thereof Apr 18 1946 (month) (day) (year)Cemetery or crematory St. Paul'sLocation Wooton18. Funeral director Irvin BennettAddress Stockton md19. 4/30/46 (Date issued by registrar)19. 4/17/46 (Date signed by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Stockton (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 16- 1946 at 9:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

## Immediate cause of death

HTN meningoitis

DURATION

Due to

Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings or operations

16 of apoplex died Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

Paul O'Dell M.D. M.D. or otherAddress 200 N. Carroll St., Baltimore, Md. Date signed 4/17/46

SEARCHED  
MAY 8 1946  
BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B.P.D.)

04163

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
90 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Lavenia C. Bennett

4. Sex

Female

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Aug 13 - 1855

8. AGE:

Years 30 Months 8 Days 11 If less than one day hrs. 0 min.

9. Birthplace.....

Sharptown Md

(Town, county, and state)

10. Usual occupation.....

House work

11. Industry or business.....

William J. Bennett

FATHER

12. Name.....

Md

Rachel A. Robinson

MOTHER

13. Birthplace.....

Md

14. Maiden name.....

George J. Bennett

15. Birthplace.....

Md

16. Informant.....

Burial

(Burial, cremation, or removal, if any)

Date thereof..... 4-17-1946

(month) (day) (year)

Cemetery or crematory.....

M. J. Bennett

17. Location.....

Sharptown

O. Sharptown

18. Funeral director.....

O. Sharptown

19. Funeral director.....

O. Sharptown

Address.....

Sharptown

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Sharptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

4/14

1946

at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/14/46

1946

to 4/14

1946

and that I last saw her alive on 4/14/46

1946

Immediate cause of death.....

Chronic Cardiac Disease

DURATION

2 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

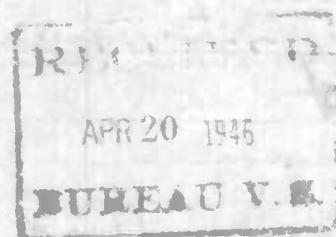
M. D. or other

Address.....

Sharptown Md

Date signed

4/17/46



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

04164

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Saint Michaels

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Peninsula General

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? One day

## 3. (a) FULL NAME

Aelia Bonnie

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

white

6. (b) Name of husband or wife

Henry Baine

7. Birth date of deceased (mo., day, yr.)

Oct-15-1870

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

5

hrs.

min.

9. Birthplace

Illinois

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

James Stillwell

12. Name

13. Birthplace

Illinois

14. Maiden name

Kennedy Stillwell

15. Birthplace

Ill

16. Informant

Guy Sharp

Address

3200 St. Washington St.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Apr 28, 1946

(month) (day) (year)

Cemetery or crematory

St Andrews

Location

Princess Anne Md

18. Funeral director

James Smith

Address

Princess Anne

19. Date filed by registrar

4/30/46

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Saint Michaels (If outside city or town limits, write RURAL and give nearest town)Street No. 3200 St. Washington St. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 20 1946 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Burned to death

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

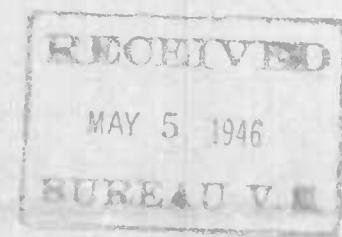
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE If death was due to external causes, fill in the following:

Accident, suicide, or homicide Decedent Date of 4/19/46Where did injury occur? Princess Anne Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) At homeMeans of injury Burned Injured at work? Yes23. SIGNATURE Henry M. Lambford Jr. D M. D. or otherAddress Princess Anne Md Date signed 4/30/46



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 126

## CERTIFICATE OF DEATH

04165-333  
Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:

Peninsula General Hosp.How long in hospital or institution? 13 Days

## 3. (a) FULL NAME

Bounds, Mrs Beatrice B.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FemaleW.Single

6. (b) Name of husband or wife

V6. (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.)

Dec. 1, 1891

8. AGE:

Years

Months

Days

If less than one day

53516

hrs.

min.

9. Birthplace

Quintland, Wicomico, Md.

(Town, county, and state)

10. Usual occupation

Print Book Dealer

11. Industry or business

Printing

FATHER

12. Name W. Jones13. Birthplace Wicomico Co., Md.14. Maiden name W. Jones15. Birthplace Wicomico Co., Md.16. Informant Mrs. Pearson, N. PearceAddress Salisbury, Md.17. Burial Burial (Burial, cremation, or removal. Which?)Date thereof 4/17/46 (month) (day) (year)Cemetery or crematory Allen MortuaryLocation Allen, Md.18. Funeral director Mr. Neil Y. JohnsonAddress Salisbury, Md.19. Date rec'd by registrar 4/20/46

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County WicomicoCity or town Quintland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

711-03-1756

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 17, 1946 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-4 1946 to 4-17 1946and that I last saw her alive on 4-17-46 1946

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Due to

Other conditions Chronic Cholecystitis

(Include pregnancy within 8 months of death)

Major findings of operations Cholecystitis & cholelithiasis Date of op. 4-8-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Flags A Fresh Md M. D. or other

Address

Salisbury, Md. Date signed 4-17-46

RECEIVED

MAY 7 1946

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94166

## CERTIFICATE OF DEATH

04166

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mattie Boyman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov. 15-1870

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

75

4

21

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral Director

Address

19. (Date rec'd by registrar)

(If registered)

## 2. USUAL RESIDENCE (HOME) OF DECLASSED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

April 6 1946 f.p.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on

Immediate cause of death

coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

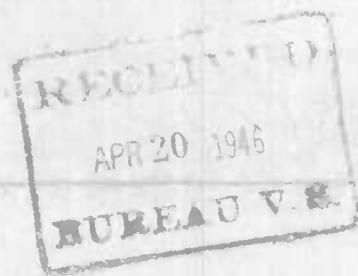
John R. Johnson, M.D.

M. D. or other

Address

9/8/46

Date signed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04167

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County

City or town

Wicomico

Salisbury P.T.D. #2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

By car

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

F

5. Color or race

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Julius Burris

7. Birth date of deceased (mo., day, yr.)

Dec. 5, 1911

6. (c) If alive, give age

37

years

8. AGE:

Years 34 Months 4 Days 19

It less than one day

hrs. min.

9. Birthplace

Accomac Co. Va. (Belle Haven)

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Fisher Palmer

FATHER

12. Name

Fisher Palmer

13. Birthplace

Belle Haven, Va.

MOTHER

14. Maiden name

Lester Kirkham

15. Birthplace

Belle Haven, Va.

16. Informant

Julius Burris

Address

Salisbury P.T.D. #2 Md.

17. Burial

(Burial, cremation, or removal. Which)

Date thereof May 24 '46

(month) (day) (year)

Cemetery or crematory

Baptist Cemetery

Location

Quantico Md.

18. Funeral director

David M. Russell

Address

Hebron Md.

19. Date record by registrar

5/29/46

20. Signature

Johnson Palmer

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Wicomico

City or town

Salisbury P.T.D. #2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 29 1946 at 5:00

21. I CERTIFY that death occurred on the date above cited; that I attended deceased from

and that I last saw him alive on April 29 1946 at 5:00

Immediate cause of death

Probably Tuberculosis

Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

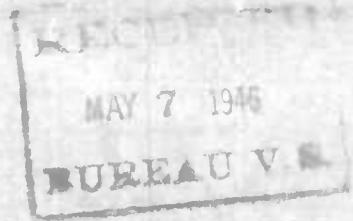
23. SIGNATURE

Johnson Palmer

M. D. or other

Address

Date signed 4/29/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (35-2)

## CERTIFICATE OF DEATH

04168

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico  
County: Salisbury

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred: 305 E. Market St.

How long in hospital or institution?.....

3. (a) FULL NAME Cora C. Carter

4. Sex: Female 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Widow

6. (b) Name of husband or wife: Alonzo F. Carter

7. Birth date of deceased (mo., day, yr.): Nov. 18-1869 8. (c) If alive, give age: dead years

8. AGE: 76 Years 4 Months 14 Days If less than one day: hrs. min.

9. Birthplace: Salisbury Maryland (Town, county, and state)

10. Usual occupation: at home

11. Industry or business: at home

MOTHER FATHER 12. Name: Jasper Connally

13. Birthplace: Wicomico Co., Md.

14. Maiden name: Unknown

15. Birthplace: Mo. Elsie Bailey

16. Informant: Address: Hobson Md.

17. Burial: Buried Date thereof: April 5-46 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory: Acorn Cemetery

Location: Salisbury Maryland

18. Funeral director: Holloway & Co. Walter R. Holloway

Address: Salisbury Maryland

19. H/15 Date read by registrar: 4-15-46

Address: Salisbury Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State: Md

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No: 305 E. Market St.

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2nd 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1941 to 1946

and that I last saw her alive on March 21 1946

Immediate cause of death: acute cardiac failure

Due to: cardio vascular disease

Due to: anemia

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op: .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .....

Date of: .....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Time of injury: .....

Injured at work? .....

23. SIGNATURE: Stephanie Doe

M. D. or other

Address: Salisbury Maryland

Date signed: 4-3-46

APR 12 1946

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20201

64169

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: St. Leonards  
County: CarolineCity or town: Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 hrs  
Hospital, Institution or street address where death occurred: P. G. HospitalHow long in hospital or institution? 24 hrs

## 3. (a) FULL NAME

Ira L. Latlin4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Ira L. Latlin7. Birth date of deceased (mo., day, yr.) May 7 19148. AGE: Years 71 Months 10 Days 13 If less than one day9. Birthplace Sussex Co., Del.  
(Town, county, and state)10. Usual occupation House work11. Industry or business Major D. Bradley12. Name Major D. Bradley13. Birthplace Del.14. Maiden name Delia Cooper15. Birthplace Del.16. Informant Ira L. LatlinAddress Mardela, Md.17. Burial Mardela Date thereof 4 23 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MardelaLocation Mardela, Md.18. Funeral director Gravemor Bros.Address Shapton19. 4/23/46 1946 4/23/46  
(Date issued by Registrar) Registrar Registrar2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State: Md County: St. LeonardsCity or town: Mardela, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No.:   
(If rural, give LOCATION)2. (a) If veteran, name war: 

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1946 at 11:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/18 1946, to 4/20 1946and that I last saw her alive on April 20 1946 1946Immediate cause of death Chronic Valvular Diseaseof heart DURATION 10 yearsDue to Due to Other conditions 

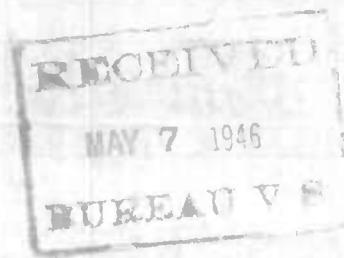
(Include pregnancy within 8 months of death)

Major findings of operations  Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE J. S. Lubman M. D. or other Address Shapton, Md. Date signed 4/23/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1460

04170

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH

County

City or town

Kicomito

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

12 years

Hospital, institution, or street address where death occurred:

P.B. Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

female

5. Color of face

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Samuel Cimino

7. Birth date of deceased (mo., day, yr.)

April 17<sup>th</sup> 1915

(6. c) If alive, give age years

35

8. AGE:

Years      Months      Days      If less than one day

31      -      3      hrs.      min.

9. Birthplace

White Haven Maryland

(Town, county, and state)

10. Usual occupation

House wife

at home

11. Industry or business

Edward Malone

Somerset Co. Maryland

12. Name

Jennie Elizabeth Malone

Jennie Elizabeth Martin

13. Birthplace

Somerset Co. Md.

Somerset Co. Maryland

14. Maiden name

Somerset Co. Md.

Somerset Co. Maryland

15. Birthplace

M. Samuel Cimino

M. Samuel Cimino

16. Informant

136 Penna. Ave. Salisbury Md.

Address

Burial

Date thereof

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

J. W. Mum. Park

Location

Salisbury Maryland

Hollings &amp; C. Walter R. Hollings

18. Funeral director

Salisbury Maryland

Address

19. 4/23/46

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MD

County

Wicomico

City or town

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

136 Penna. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr. 20 1946, at 7:20 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 16 1946, to Apr. 20 1946

and that I last saw her alive on Apr. 20 1946

Immediate cause of death

Pulmonary Embolism

Due to

Due to

Other conditions Post Partum, 4 days

Uncomplicated Normal Spontaneous Delivery

Major findings of operations

Date of op.

Autops results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

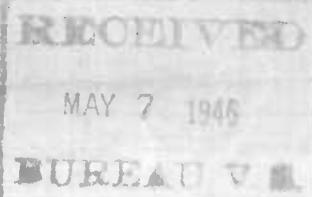
33. SIGNATURE

M. D. or other

Address

Salisbury, Md.

Date signed 4/20/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

04171

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

3

hrs. .... min.

9. Birthplace.....

(Town, County, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant.....

Address

17. Burial

(Burial, cremation, or removal, which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address

19. (Date read by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

East

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

29 March 1946 to 1 April 1946

and that I last saw him alive on 1 April 1946

Immediate cause of death.....

Prematurity

DURATION

3 days

Due to.....

Due to.....

Other conditions.....

Bilateral Pneumonia

atelectasis (Include pregnancy within 3 months of death) 3 days

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

3. SIGNATURE

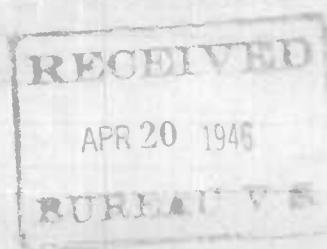
Registrar

Address

M. D. or other

Date signed

2 April 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

04172

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial General Hospital  
How long in hospital or institution? 6 hrs 38 min

## 3. (a) FULL NAME

Conrad - Baby Boy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male W Single

## B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 9 - 1946  
B. (c) If alive, give age ..... years8. AGE: Years 0 Months 0 Days 0 If less than one day  
hrs. 0 min.9. Birthplace Salisbury, Wicomico, Md  
(Town, county, and state)

## 10. Usual occupation.

## 11. Industry or business

12. Name Robert S. Conrad  
13. Birthplace Ohio14. Maiden name Mary Louise Stewart  
15. Birthplace Pennsylvania16. Informant Robert S. Conrad  
Address Snow Hill, Md17. Burial, cremation, or removal, Which? Burial  
Date thereof April 10/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Memorial  
Location Snow Hill, Md18. Funeral director DeArme  
Address Snow Hill, Md19. (Date read by registrar) 4/12/46 DeArme Registrar  
Address Salisbury, Md Date signed 4/12/46

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury (If outside city or town limits, write RURAL and give nearest town)Street No. 100 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9 April 1946 at 2 50 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-9 1946, to 4-9 1946 and that I last saw him alive on 19.Immediate cause of death CongenitalPulmonary Atelectasis

DURATION

5 hoursDue to Prematurity5 hours

Due to:

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

23. SIGNATURE DeArme 4/10

M. D. or other

Address Salisbury, Md Date signed 4/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 23 1946  
BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

## CERTIFICATE OF DEATH

Reg. Dist. No. 11151523

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 21 days

## 3. (a) FULL NAME

Davis, Mrs. Annie E.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white Widowed

6.(b) Name of husband or wife

James T. Davis

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 22 - 1866

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace:

Shadetree, WorcesterMD

(Town, county, and state)

10. Usual occupation:

None

11. Industry or business

William Tarr

MOTHER FATHER

12. Name:

William Tarr

13. Birthplace

Maryland

14. Maiden name:

Harriett Sturgis

15. Birthplace

Maryland

16. Informant:

M. George E. Davis

Address

3800 E. Winona Ave., Newmarket

17. Burial

(Burial, cremation, or removal, which?)

Date thereof: Sept. 22, 1946

(month)

(day)

(year)

Cemetery or crematory

Young Hill

Location

Shadetree, MD

18. Funeral director:

Hearne & Davis

Address

Young Hill, MD19. 4/28/46 (Date rec'd by registrar)19. 4/26/46 (Date signed)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Shadetree

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. #1

(If rural, give LOCATION)

2.(a) If veteran, name war

W.W. I

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 25 1946, at 6:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 5 1946 to April 25 1946end that I last saw her alive on April 25 1946

Immediate cause of death

Ca. of Fever.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

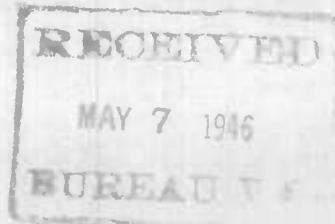
Injured at work?

23. SIGNATURE

R. B. Bush

M. D. or other

Address 11151523 Date signed 4/26/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Hanson

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-1

## CERTIFICATE OF DEATH

04175

Reg. Dist. No. 333

1. PLACE OF DEATH:  
 County Wicomico  
 City or town Salisbury (If outside city or town limits, write RURAL and give nearest town) 28 hours  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred: Memorial General Hospital  
 How long in hospital or institution? 27 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

For newborn infants give residence of mother  
 State Maryland County Somerset  
 City or town Pocomoke City (Outside city or town limits, write RURAL and give nearest town)  
 Street No. RT #1 (If rural, give LOCATION) ✓

2.(a) If veteran, name war.

## 3. (b) Social Security Number

## 3. (a) FULL NAME

Davis - Betty  
 4. Sex Female 5. Color or race C 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife George Davis  
 7. Birth date of deceased (mo., day, yr.) January 1901 8. (c) If alive, give age 80 years  
 8. AGE: 45 Years 0 Months 0 Days 0 If less than one day hrs. 0 min.  
 9. Birthplace Halifax County North Carolina (Town, county, and state)  
 10. Usual occupation Domestic  
 11. Industry or business

MOTHER FATHER  
 12. Name Thomas Poyton  
 13. Birthplace North Carolina  
 14. Maiden name Carolina Edmonds  
 15. Birthplace North Carolina  
 16. Informant George Davis  
 Address Pocomoke City, Md RT#1

17. Burial Halls Hill Cemetery Date thereof April 13, 1946  
 (Burial, cremation, or removal. White box)  
 Cemetery or crematory Pocomoke City, Md  
 Location 8 Harvey Bledsoe

18. Funeral director J. Harvey Bledsoe  
 Address Pocomoke City, Md  
 19. (Date rec'd by registrar) April 31, 1946 Anne E. Davis Registrar  
 (Date rec'd by registrar) April 31, 1946 Anne E. Davis Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1946 at 3:15  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 6, 1946 to Apr. 9, 1946, and that I last saw her alive on Apr. 9, 1946.

Immediate cause of death

Syphilitic HEART DISEASE

Due to

Due to

Other conditions Myocardial Hypertrophy

(Indicate pregnancy within 3 months of death)

Major findings of operations none Date of op.Autopsy results confirmatory  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

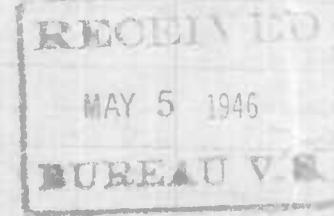
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Address 11 Rivers Hansen, M.D. M. D. or other Salisbury, Md. Date signed 4/10/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 933

## CERTIFICATE OF DEATH

64176  
Reg. Dist. No. 333

1. PLACE OF DEATH: *Wicomico*  
County: *Pittsville*

City or town: *Pittsville* (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Lifetime*

Hospital, institution, or street address where death occurred: *P.O. #2*

How long in hospital or institution? .....

3. (a) FULL NAME

*Mollie Jane Dennis*

3. (b) Social Security Number

4. Sex: *Female* 5. Color or race: *White* 6. (a) Single, married, widowed, or divorced: *Married*

6. (b) Name of husband or wife: *John Handy Dennis*

7. Birth date of deceased (mo., day, yr.): *Aug. 30-1879* 6. (c) If alive, give age: *75* years

8. AGE: *66* Years *7* Months *4* Days If less than one day

9. Birthplace: *Parsonbury Maryland* (Town, county, and state)

10. Usual occupation: *House wife*

11. Industry or business: *at home*

12. Name: *Richard Richardson*

13. Birthplace: *P.O. Pittsville Maryland*

14. Maiden name: *Mary Parker*

15. Birthplace: *Parsonbury Md.*

16. Informant: *M. J. Handy Dennis*

Address: *P.O. #2 Pittsville Maryland*

17. Burial: *Buried* Date thereof: *April 7 1946* (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory: *Pittsville Cem.*

Location: *Pittsville Maryland*

18. Funeral director: *Walter R. Hoffman*

Address: *Salisbury Maryland*

19. (Dated by registrar) *4/7/46* (Date signed by registrar) *1946*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: *Md.* County: *Pittsville*

City or town: *Pittsville* (If outside city or town limits, write RURAL and give nearest town)

Street No.: *P.O. #2* (If rural, give LOCATION)

2. (a) If veteran, name war: .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *April 4 1946* at *9:30p*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Westover* to *Westover* and that I last saw him *Westover* on *Westover* 19.

Immediate cause of death: *congestive heart failure*

Due to: *chronic myocarditis*

Due to: *congestive heart failure*

Other conditions: *congestive heart failure*

(Include pregnancy within 3 months of death)

Major findings of operations: *none*

Date of op.: *none*

Autopsy results: *none*

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: *no*

Accident, suicide, or homicide: Date of: .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: *fall* Injured at work? *no*

23. SIGNATURE: *Richardson, M. J. Handy Dennis*

M. D. or other: *Physician*

Date signed: *4/5/46*

RECEIVED

APR 20 1946

BUREAU V.E.



Dr. Hanson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04177

CERTIFICATE OF DEATH

Reg. Dist. No. 733

1. PLACE OF DEATH:

County

Wicomico

City or town

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 day

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

3. (a) FULL NAME

Dorrell George Albert

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 23 - 1946

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Salisbury, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Geo. Albert Dorrell

13. Birthplace

Salisbury, Md.

MOTHER

14. Maiden name

Elma C. Carg

15. Birthplace

Rehoboth, Del.

16. Informant

Geo. Albert Dorrell

Address

Salisbury, Md.

17. (Burial, cremation, or removal, which?)

Burial Date thereof 4-25-46

(month) (day) (year)

Cemetery or crematory

St. P.

Location

Delmar Del

18. Funeral director

W. S. Mason Co.

Address

Delmar Del

19. (Date rec'd by registrar)

4/25/46

19. (Date of death)

4/25/46

19. (Date of death)

4/25/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Wicomico

City or town

Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No.

310 W. Victoria (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1946 at 4:55

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 23 1946 to Apr. 24 1946 and that I last saw him alive on Apr. 24 1946

Immediate cause of death

Prematurity

Due to

Premature Labor

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

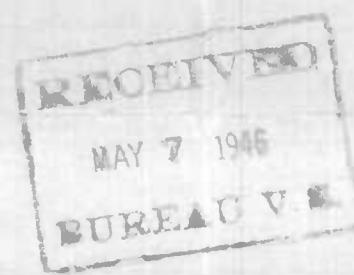
Injured at work?

23. SIGNATURE

Spencer Hanson, M.D. M.D. or other

Address

Spencer Hanson, M.D. Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Yearman

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

04178

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

30 years

Hospital, Institution, or street address where death occurred:

P.O. #2

How long in hospital or institution?

## 3. (a) FULL NAME

Battie M. Discoll

4. Sept.

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age

years

8. AGE:

Years      Months      Days      If less than one day

74

—

16

hrs.

min.

8. Birthplace

Wango, Md.

(town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral Director

Address

19. (Date record registered)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

County

If outside city or town limits, write RURAL and give nearest town

P.O. #2

If rural, give LOCATION

2. (a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 12 1946 at 19.46

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

January 3 1946 to April 12, 1946, and that I last saw her alive on April 12, 1946.

Immediate cause of death

Cerebrovascular Disease.

DURATION

7

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injury

Injured at work?

23. SIGNATURE

John H. Yearman M.D.

M. D. or other

Address

230

Camden Ave

Date signed

April 13, 1946

Salisbury, Md.

RECEIVED

MAY 5 1946

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04179

## CERTIFICATE OF DEATH

Reg. Dist. No. 233

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 3 hrs.

Hospital, Institution, or street address where death occurred:

Peninsula Gen. HospitalHow long in hospital or institution? About 3 hrs.

## 3. (a) FULL NAME

Duke, Walter G.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.W(Married)B. (b) Name of husband or wife Betty Ann Elliott Duke8. (c) If alive, give age 19 years7. Birth date of deceased (mo. day, yr.) 10 Dec 19218. AGE: Years 24 Months 4 Days 4 If less than one day hrs. min.9. Birthplace Greenwood, Del.  
(Town, county, and state)10. Usual occupation Soldier U.S. Army

## 11. Industry or business

12. Name Charles Richard Duke13. Birthplace Virginia14. Maiden name Juliet WYNN15. Birthplace Richmond Virginia16. Informant Wife of Deceased & Army RecordsAddress Burial17. (Burial, cremation, or removal, which?) Burial Date thereof Apr. 17-1946  
(month) (day) (year)Cemetery or crematory Old FellowesLocation Seaford Delaware18. Funeral director Mrs. Julie Kyatt BoyerAddress Hanington, Delaware19. 6/8/46 Date read by registrar19. 4/14/46 Date signed

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County KentCity or town Dover  
(If outside city or town limits, write RURAL and give nearest town)Street No. Dover Army Airfield  
(If rural, give LOCATION)2. (a) If veteran, name war World War II (was still in Service)

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 14 April F 1946 at 3:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Decedent Emergency Report 19.and that I last saw him alive on Admission to Hosp. 14 Apr. 1946Immediate cause of death Internal Hemorrhage DURATIONDue to Fractured Pelvis, Severe  
Contusions of BodyDue to Aircraft AccidentOther conditions Fract rt. wrist, x

(Include pregnancy within 3 months of death)

Major findings of operations

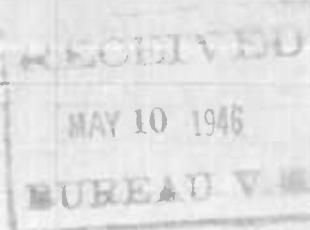
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Aircraft Accident Date of 14 April '46Where did injury occur? (Near) Pittsilk (City or town) (County) (State)Injured at home, farm, industry, public place (where?) In WoodsMeans of injury Aircraft Accident Injured at work? Yes23. SIGNATURE Oliver Fisher Date 4/14/46Address Seaford, Delaware Date signed 4/14/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

04180

Reg. Dist. No. 333

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County NicomicoCity or town Heard Pittsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Pearl Dukes

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White married

8. (b) Name of husband or wife

Henry Dukes

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10

1886

8. AGE:

Years

Months

Days

If less than one day

60

8

6

hrs.

min.

9. Birthplace

Ocean City, Md.

(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

John Downing

12. Name

John Downing

13. Birthplace

Ocean City, Md.

14. Maiden name

Elizabeth Downing

15. Birthplace

Ocean City, Md.

16. Informant

Mayel Bull

Address

Pittsville, Md.

17. Burial

Date thereof April 17, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Ever Green Cemetery

Location

Berlin, Md.

18. Funeral director

Wm. Howard Wells

Address

Pittsville, Md.

19. (Date record by registrar)

4/17/46Signature John Dukes

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State CountyCity or town (If outside city or town limits, write RURAL and give nearest town)Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 15th 1946, at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1944 19, to April 16, 1946 19, and that I last saw her alive on April 16, 1946 19.Immediate cause of death myocarditisChronic

DURATION

2 yrsDue to Hypertension

3

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

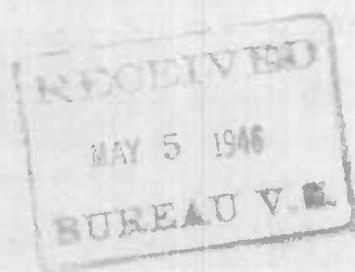
Means of injury

Injured at work?

23. SIGNATURE Frank Lewis

M. D. or other

Address Pittsville, Md. Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

04181

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County

Baltimore

City or town

Baltimore in

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years

Hospital, Institution, or street address where death occurred:

no

How long in hospital or institution? no

## 3. (a) FULL NAME

James Elgy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male a a married

B. (b) Name of husband or wife Mary n Elgy frontman

7. Birth date of deceased (mo., day, yr.)

1888

6. (c) If alive, give age years

8. AGE: Years 57 Months - Days - It less than one day hrs. min.

9. Birthplace Quantico md

(Town, county, and state)

10. Usual occupation Farmer

## 11. Industry or business

Same as above

MOTHER FATHER

12. Name James Elgy

13. Birthplace Quantico md

14. Maiden name Josephine Morris

15. Birthplace Baltimore

16. Informant Mary Elgy

Address

17. Burial Date thereof May 1-1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory Baltimore

Location Baltimore md

18. Funeral director James F. Stewart

Address

Baltimore 333

19. (Date recd by registrar) 5/1/46

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Worcester

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

2.(a) If veteran, name war no

## 3. (b) Social Security Number

no

## MEDICAL CERTIFICATION

20. DATE OF DEATH 26 April 1946 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 April 1946 to 26 April 1946 and that I last saw h. f. m. alive on 26 April 1946.

Immediate cause of death

Cerebral apoplexy

DURATION

Due to

23

Due to

0048

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Arthur P. Browne M.D.

M. D. or other

Address

Date signed

4/25/46

RECEIVED  
MAY 7 1946  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19102

04182

Reg. Dist. No. 333

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Wilmington

City or town

Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

## 3. (a) FULL NAME

Samuel Hale

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

a. a.

widower

6. (b) Name of husband or wife

Lorraine Hale

Dead

6. (c) If alive, give age

no

years

7. Birth date of deceased (mo. day, yr.)

about 1869

8. AGE:

Years

Months

Days

If less than one day

about 77

hrs.

min.

9. Birthplace

Quintilia, Md.

(Town, county, and state)

10. Usual occupation

was a laborer when worked

11. Industry or business

lumber as above

MOTHER FATHER

12. Name

Henry Hale

13. Birthplace

Baltimore, Md.

14. Maiden name

Lorraine Harmon

15. Birthplace

Quintilia, Md.

16. Informant

Daniel Hale

Address

Salisbury, Md.

17. Burial

Date thereof April 26, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Quintilia, Md.

Location

Quintilia, Md.

18. Funeral director

James F. Stewart

Address

Salisbury, Md.

19. Date rec'd by registrar

1946

Signature

J. L. Johnson

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Wilmington

City or town

Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

304 Hospital St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

no

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1946 at 6:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 12 1946 to April 20 1946

and that I last saw him alive on April 20 1946

Immediate cause of death

Cardiac Decompensation

DURATION

8 days

Due to

Renal Hypertension

Due to

Stomach Nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. L. Johnson, M.D.

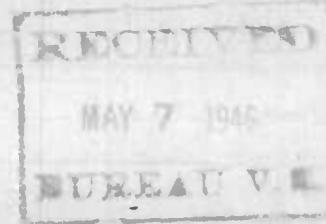
M. D. or other

Address

800 W. Main St., Salisbury

Date signed

4-24-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04183

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

9-45

VS A15

1. PLACE OF DEATH: *Salisbury*  
 County: *Wicomico*  
 City or town: *Salisbury*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *11 years*  
 Hospital, institution or street address where death occurred: *R.B. Hospital*  
 How long in hospital or institution?

3. (a) FULL NAME  
*Severell Emory Griffis*

4. Sex: *Male* 5. Color of Face: *White* 6. (a) Single, married, widowed, or divorced: *Married*

6. (b) Name of husband or wife: *Annie Mae Griffis*

7. Birth date of deceased (mo., day, yr.): *Nov. 30-1889* 6. (c) If alive, give age: *75* years

8. AGE: *56* Years *5* Months *—* Days *If less than one day* hrs. *—* min.

9. Birthplace: *R.D. Berlin Md.* (Town, county, and state)

10. Usual occupation: *Prop of Restaurant*

11. Industry or business: *Edward Griffis*

FATHER: 12. Name: *R.D. Berlin Md.*

13. Birthplace: *R.D. Berlin Md.*

MOTHER: 14. Maiden name: *Rose Zimmerman*

15. Birthplace: *R.D. Berlin Md.*

16. Informant: *Mr. Annie M. Griffis*

Address: *214. West Main St. Salisbury Md.*

17. (Burial, cremation, or removal: Which?) *Buried* Date thereof: *May 4-1946* (month) (day) (year)

Cemetery or crematory: *Mrs. Mem. Park*

Location: *Salisbury Md.*

18. Funeral director: *Holloway & Son Walter R. Holloway*

Address: *Salisbury Md.*

19. (Date rec'd by registrar) *5/4/46* Certified by: *Johns* Registrar: *Local*

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: *Md.* County: *Wicomico*  
 City or town: *Salisbury* (If outside city or town limits, write RURAL and give nearest town)  
 Street No: *214 W. Main St.* (If rural, give LOCATION)

2. (a) If veteran, name war: \_\_\_\_\_

3. (b) Social Security Number: \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *April 30-1946*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1946* to *1946* and that I last saw him *alive* on *April 30* *1946*

Immediate cause of death: *Cerebral Hemorrhage*

Due to: *Arteriosclerosis & hypertension*

Due to: *hypertension*

Other conditions: \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations: \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results: \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

IN VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Place of injury: \_\_\_\_\_ Injured at work: \_\_\_\_\_

3. SIGNATURE: *Johns*

M. D. or other: \_\_\_\_\_ Date signed: *5/3/46*

Address: *Salisbury Md.*

RECEIVED

MAY 9 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

04184

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

## 1. PLACE OF DEATH:

County St. LouisCity or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

Wren's Pushy and Queen, Broad St.

How long in hospital or institution?

## 3. (a) FULL NAME

Margat Road Queen

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Ralph W. Queen

## 7. Birth date of deceased (mo., day, yr.)

Sep. 14, 1888

## 8. AGE: Years

57

## Months

7

## Days

16

## If less than one day

hrs. min.

## 9. Birthplace

Salisbury, St. Louis, Md.

(Town, county, and state)

## 10. Usual occupation

At Home

## 11. Industry or business

Terry L. Todd

## 12. Name

Terry L. Todd

## 13. Birthplace

Salisbury, Md.

(Town, county, and state)

## 14. Maiden name

Agnes Phelps

## 15. Birthplace

Maryland

(Town, county, and state)

## 16. Informant

Ralph W. Queen

Address

Salisbury, Md.

(City or town)

(County)

(State)

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

5/30/46

Cemetery or crematory

Terry L. Todd

Location

Salisbury, Md.

## 18. Funeral director

De Hill Johnson Co.

Address

Salisbury, Md.

(City or town)

(County)

(State)

## 19. (Date rec'd by registrar)

19

Registrar

Signature

Address

Date signed

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

St. Louis

City or town

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

707 Main Street

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Apr. 30, 1946, at 6 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

19

## Immediate cause of death

Coronary Occlusion

Duration

## Due to

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

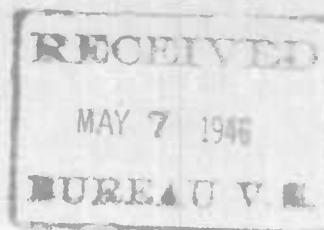
## 23. SIGNATURE

Oscar L. Giesler, M.D.

M. D. or other

Address

Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

04185

## CERTIFICATE OF DEATH

Reg. Dist. No. 339

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County..... Wicomico  
City or town..... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 8 Years

Hospital, institution, or street address where death occurred:

John B. Parsons Home

How long in hospital or institution?.....

## 3. (a) FULL NAME

Elizabeth E. Hilghman  
4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced  
Female White Widowed

6. (b) Name of husband or wife..... Theodore C. Hilghman

7. Birth date of deceased (mo., day, yr.)..... 6. (c) If alive, give age..... years  
March 31 1870

8. AGE: Years Months Days If less than one day  
76 0 5 ..... hrs. ..... min.

9. Birthplace..... Wicomico, Co. Md  
(Town, county, and state)

10. Usual occupation..... None

11. Industry or business.....

FATHER 12. Name..... William Washburn  
13. Birthplace..... Wicomico Co. Md

MOTHER 14. Maiden name..... Annie Carey  
15. Birthplace..... Wicomico, Co. Md

16. Informant..... Mrs Henry Jone

Address..... Eden, Md

17. Burial..... Date thereof 4/7/40  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Methodist Cemetery

Location..... Shad Point, Md

18. Funeral director..... The Hill & Johnson Co.

Address..... Salisbury, Md

19. (Date rec'd by registrar) 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Md County..... Wicomico

City or town..... Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... John B. Parsons Home  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 5 40 at 12 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 25 1940 to April 5 1940 and that I last saw her alive on April 1 1940

Immediate cause of death.....

Cerebral hemorrhage

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed..... Apr 6

RECEIVED

APR 30 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Warner

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

04186

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County

Wicomico

City or town

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Community General Hospital

How long in hospital or institution?

2 days

## 3. (a) FULL NAME

Hitch, Mrs. Robert J.

4. Sex

W

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Widowed

B. (b) Name of husband or wife

Edith B. Hitch

7. Birth date of deceased (mo., day, yr.)

July 28, 1873

6. (c) If alive, give age

years

8. AGE:

72

8

18

Days

1

if less than one day

hrs.

min.

9. Birthplace

Wicomico Co., Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Robert John Hitch

MOTHER FATHER

12. Name

Wicomico Co., Md

13. Birthplace

Sarah Phoebe

14. Maiden name

Wicomico Co., Md

15. Birthplace

Heward C. Hitch

16. Informant

Salisbury, Md

Address

Burial

Date thereof

(month) (day) (year)

17. (Burial, cremation, or removal. Which?)

Wicomico Memorial Park

Cemetery or crematory

Salisbury, Md

Location

The Hill &amp; Johnson Co.

18. Funeral director

Address

Burial, Cremation, or Removal

Date signed

Registar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Wicomico

City or town

Salisbury

Street No.

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war

(If rural, give LOCATION)

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 15- 1946 at 12:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 13, 1946, to Apr 15, 1946

and that I last saw him alive on Apr 14, 1946

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Warner M.D.

Address

M. D. or other

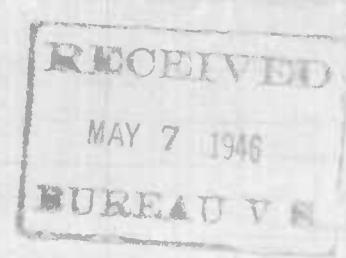
Date signed

RECEIVED

MAY 7 1945

BUREAU OF





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1960

## CERTIFICATE OF DEATH

Reg. Dist. No. 333-1118265

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 5 days

## 3. (a) FULL NAME

Holland, Mr. William R

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 7 1886

8. AGE:

Years

Months

Days

If less than one day

59 11 8 hrs. min.

9. Birthplace

Cresfield

(Town, county, and state)

10. Usual occupation

Butcher

11. Industry or business

Beef

MOTHER

FATHER

12. Name

William R. Holland

13. Birthplace

Cresfield

14. Maiden name

Walter Adeline male

15. Birthplace

Cresfield

16. Informant

Wally Holland

Address

Wetmore Rd

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 4/17/46

(month) (day) (year)

Cemetery or crematory

Cresfield Cemetery

Location

Cresfield Rd

18. Funeral director

W. R. Holland

Address

25 N. 19th St., Salisb.

19. (Date rec'd by registrar)

4/16/46

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County SomersetCity or town Cresfield (If outside city or town limits, write RURAL and give nearest town)Street No.  (If rural, give LOCATION) ✓2.(a) If veteran, name war None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1946 at 2:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 10 1946 to Apr. 15 1946and that I last saw him alive on Apr. 15 1946

Immediate cause of death

Congestive Heart Failure, Acute

DURATION

Due to

Due to

Other conditions Fractured Ribs, rightwith Traumatic Hemothorax

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Undetermined Date of uncertainWhere did injury occur? Cresfield (City or town) Somerset (County) MD (State)Injured at home, farm, industry, public place (where) NoneMeans of injury Undetermined Injured at work? NO23. SIGNATURE James Hanson, M.D.

M. D. or other

Address Salisbury, MD Date signed 4-16-46

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MAY 7 1946

BUREAU OF

Q.C. 2003.207

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1629

## CERTIFICATE OF DEATH

04189

Reg. Dist. No. 339

1. PLACE OF DEATH:  
County... Wicomico

City or town... Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Peninsula General Hospital

How long in hospital or institution? 39 hrs.

3. (a) FULL NAME

Jackson - George W.

4. Sex Male 5. Color or race C 6. (a) Single, married, widowed, or divorced Don't know

6. (b) Name of husband or wife Don't know

7. Birth date of deceased (mo., day, yr.) about 1884 B. (c) If alive, give age Don't know years

8. AGE: Years about 62 Months - Days - If less than one day hrs. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business same as above

12. Name Don't know

13. Birthplace Don't know

14. Maiden name Don't know

15. Birthplace Don't know

16. Informant Peninsula General Hospital

Address Salisbury, Md.

17. Burial Burial Date thereof Apr. 27, 1946  
(Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory Public

Location Salisbury, Md.

18. Funeral director Jessie T. Stewart

Address Salisbury, Md.

19. (Date rec'd by registrar) 4/27/46

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Allen (If outside city or town limits, write RURAL and give nearest town)

Street No. no (If rural, give LOCATION)

2. (a) If veteran, name war Don't know

3. (b) Social Security Number Don't know

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4 - 24 1946, at 8:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 to 1946, to 1946 to 1946, and that I last saw deceased alive on 1946.

Immediate cause of death Brain damage

subarachnoid hemorrhage

due to Fractured skull

Due to Blow on head

DURATION

4 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4-22-46

Where did injury occur? Allen (City or town) Wicomico (County) Md. (State)

Injured at home, farm, industry, public place (where?) home

Means of injury unknown Injured at work? No

23. SIGNATURE Jesse T. Stewart M. D. or other Surgeon

Date signed 4/27/46

Address Salisbury, Md.

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MAY 7 1946

BUREAU F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

04190

Reg. Dist. No. 333

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Salisbury, Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

11/16/46

Hospital, institution, or street address where death occurred:

no

How long in hospital or institution?

no

## 3. (a) FULL NAME

Mary Stevens Waller Jackson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

A. A.

married

6. (b) Name of husband or wife

Harrison Jackson

yes

6. (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

about 1871

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, County, and state)

10. Usual occupation

House wife

11. Industry or business

same as above

12. Name

Elsieia Parson

13. Birthplace

Salisbury, Md.

14. Maiden name

Charlotte Parsons

15. Birthplace

Salisbury, Md.

16. Informant

Harrison Jackson

Address

Salisbury, Md.

17. Burial

(Burial, cremation, or removal. When?)

Date thereof

2.0.1946

(month) (day) (year)

Cemetery or crematory

Harrison Jackson

Location

Salisbury, Md.

18. Funeral director

James D. Stewart

Address

Salisbury, Md.

19. (Date read by registrar)

11/30/46

D. J. Johnson

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Salisbury, Md.

City or town

Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

no

## 3. (b) Social Security Number

no

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

4-17 1946 at 5:40 P.M.

2E. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-16 1946 to 4-17 1946

and that I last saw her alive on 4-17 1946

Immediate cause of death Congestive Heart

failure

Due to Arteriosclerotic Hyper

Tension

Due to Chronic Glomerulonephritis

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

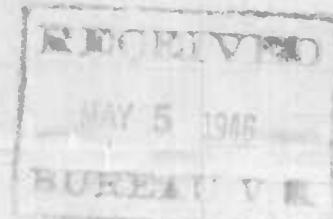
## 23. SIGNATURE

E. G. Burnell, M.D.

M. D. or other

Address 800 W. Main St.

Date signed 4-18-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

04191

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *Nicomis*  
County *Powellville*

City or town *Powellville*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Lifetime*  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME *Henry Walter Jones*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Laura C. Jones*

7. Birth date of deceased (mo., day, yr.) *Dec. 3 1867* 69 years

8. AGE: Years *78* Months *4* Days *22* If less than one day

9. Birthplace *Powellville Md.*  
(Town, county, and state)

10. Usual occupation *Retired Farmer and lumber man*

11. Industry or business *Lumber man*

12. Name *Eli Chester Jones*

13. Birthplace *Powellville Md.*

14. Maiden name *Clarissa Richardson*

15. Birthplace *Powellville Md.*

16. Informant *H. H. Walter Jones*

Address *214 Hazel Ave. Salisbury Md.*

17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *April 29-1946* (month) (day) (year)

Cemetery or crematory *Dennis Cem*

Location *Powellville Md.*

18. Funeral director *Holloway & C. Walter P. Holloway*

Address *Salisbury Maryland*

19. (Date read by registrar) *4/29/46* *Frank P. Lewis* *E. I. Registrar*

2. USUAL RESIDENCE (HOME) OF DECEDENT:  
(For newborn infants, give residence of mother)

State *Md.* County *Nicomis*

City or town *Powellville*  
(If outside city or town limits, write RURAL and give nearest town)

Street No.   
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

April 25 1946 7500

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 to 9 1946 to day of death 1946 and shall last saw him alive on April 29, 1946 1946

Immediate cause of death *Myocarditis chronic*

*liposarcoma*

Due to *Over int nephritis*

Due to

Other conditions *Obesity*

*Diabetes mellitus*

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

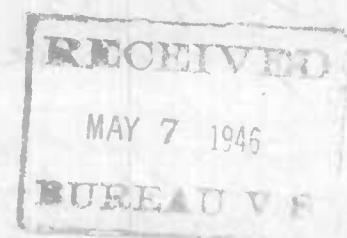
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Frank P. Lewis* M. D. or other

Address *Salisbury Maryland* Date signed *4/26/46*



**CERTIFICATE OF DEATH**

04192

Reg. Diat. No. 3-333

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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VS A15

1. PLACE OF DEATH: *Wisconsin*  
County.....  
City or town..... *St. Clouds*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... *57 yrs.*  
Hospital, Institution, or street address where death occurred:  
\_\_\_\_\_  
How long in hospital or institution?..... *✓*

3. (a) FULL NAME			
Olivia Emma			
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
Female	White	Widow	
6. (b) Name of husband or wife... John D. H. Lewis			
7. Birth date of deceased (mo., day, yr.)			
8. AGE: Years Months Days It less than one day			
80	2	13	hrs. mi.
Feb. 50 1866			yes

9. Birthplace..... *Maryland.*  
(Town, county, and state)  
10. Usual occupation..... *Housewife*  
11. Industry or business..... *Housework.*  
12. Name..... *John H. Bunting*  
13. Birthplace..... *Md.*  
14. Maiden name..... *Eliza Johnson*  
15. Birthplace..... *Md.*

16. Informant mrs. James Rae Shockey  
Address Petersburg Md.  
17. Bureau Date thereof April 20 1944

(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory ..... Pittsville  
Location ..... Pittsville, Md.  
16. Funeral director ..... M. Pascal Watson

Address Silkyville, Ind.  
19. 11/20/1946 Laurel D. Johnson  
(Date rec'd by registrar) Registrant

2. **USUAL RESIDENCE (HOME) OF DECEASED:**  
 (For newborn infants give residence of mother)

State Maryland. County Wicomico  
 City or town Hilliards (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1724. (If rural, give LOCATION)

2.(a) If veteran, name war —

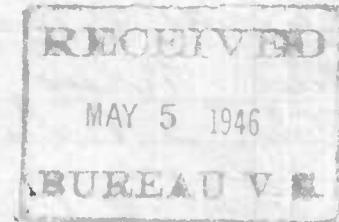
Lewis		3. (b) Social Security Number
MEDICAL CERTIFICATION		
2D. DATE OF DEATH	April 18, 1946	
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19, 1945, 19..... to April 7, death and that I last saw her alive on April 8, 1946, 19.....		
Immediate cause of death	myocarditis chronic	
Due to	2	
Due to	hypertension cerebral hemorrhage 3 days before death	
Other conditions		

(Include pregnancy within 8 months of death)			
Major findings of operations.....	Date of op.....		
Autopsy results.....			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following:			
Accident, suicide, or homicide.....	Date of.....		
Where did injury occur? .....	(City or town) .....	(County) .....	(State) .....
Injured at home, farm, industry, public place (where?) .....			
Means of Injury	Injured at work?		

23. SIGNATURE *Frank R. Lewis MD*  
M. D. or other *and Villars SW*  
Address *1219 4th* Date signed *8-19-44*

RECEIVED BY THE UNITED STATES GOVERNMENT

RECEIVED BY THE SECRETARY OF STATE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

04193

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WisconsinCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, institution, or street address where death occurred:

117 S. Taylor St.

How long in hospital or institution?

## 3. (a) FULL NAME

Clara L. Livingston

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife

Frank Livingston6. (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.)

Jan 2, 18848. AGE: Years 62 Months 3 Days 4 If less than one day hrs. 00 min. 00

9. Birthplace

Wisconsin Co. Md.

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

Laure Clayton Foods

FATHER

12. Name John Clayton Foods

13. Birthplace

Wisconsin Co. Md.

MOTHER

14. Maiden name Laura A. Brittington

15. Birthplace

Wisconsin Co. Md.

16. Informant

M. Livingston Livingston

Address

Salisbury, Md.

17. Burial

Date thereof 4/19/46 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Parsons Cemetery

Location

Salisbury, Md.

18. Funeral director

The Will & Johnson

Address

Salisbury, Md.

19. (Date rec'd by registrar)

1946

Date signed

1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County WisconsinCity or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 117 S. Taylor St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 6, 1946 at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 6, 1946 to April 6, 1946 and that I last saw her alive on April 5, 1946

Immediate cause of death

cerebral hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Registrar

M. D. or other

Address

Date signed

Parsons Cemetery  
Salisbury, Md.  
Apr. 7

RECEIVED

APR 30 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Grange

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3

04194

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County

City or town

McComish

Salisbury, Md.

(If outside city or town limits, write MURAY and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

RD #2 (or 2nd st.)

How long in hospital or institution?

3. (a) FULL NAME

Emory Clarence Lowe

4. Sex

5. Color of face

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

74

10

8

hrs.

min.

9. Birthplace

(Town, county, and state)

Panomutus, Md.

10. Usual occupation.

Retiree

11. Industry or business

John Lowe

12. Name

Sussex Co. Del.

13. Birthplace

Sussex Co. Del.

14. Maiden name

Sarah Palmer

15. Birthplace

Sussex Co. Del.

16. Informant

Mrs. Fannie Lowe

Address

RD #2 or 2nd st. Salisbury, Md.

17. Burial

Date thereof

(month) (day) (year)

(Burial, cremation, or removal with?)

Aug. 15, 1946

Cemetery or crematory

Graveside, J. W. Johnson

Location

Salisbury, Md.

18. Funeral Director

Hoffman & Weller, R. Johnson

Address

Salisbury, Md.

19. Date record by registrar

1946

(Date record by registrar)

2. USUAL RESIDENCE (HOME) OF DECEDENT:

(For newborn infants give residence of mother)

State

County

City or town

City or town

Street No.

Street No.

RD #2 (or 2nd st.)

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 12th 1946

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw him alive on April 12th 1946

Immediate cause of death

Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work? (City or town) (County) (State)

Injured at work? (City or town) (County) (State)

23. SIGNATURE

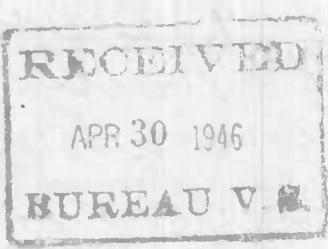
J. R. Grange M.D.

M. D. or other

Address

Salisbury, Md.

Date signed 9-12-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 330

04195

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9-45-14

VS A15

## 1. PLACE OF DEATH:

County: WicomicoCity or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 8 days

## 3. (a) FULL NAME

Hudsonary Lillian Alice

4. SEX

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white

## 6. (b) Name of husband or wife

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

Nov. 25, 1944

8. AGE:

Years

Months

Days

If less than one day

1

4

22

hrs.

min.

## 9. Birthplace

Salisbury Wic Co. Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

Maurice Hudson

MOTHER FATHER

12. Name

Maurice Hudson

13. Birthplace

Md.

MOTHER

14. Maiden name

Anna Bergman

15. Birthplace

Md.

16. Informant

Maurice Hudson

Address

Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof  
(month) (day) (year)  
4/19/45

Cemetery or crematory

Evergreen

Location

Berlin Md

## 18. Funeral director

Anna A. Barber

Address

Berlin Md19. 4/19

19.

(Date rec'd by registrar)

19. 4/26

19.

Date signed

Hazel E. Johnson

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MdCounty: Wic.City or town: Ocean City Md

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

April 17 1946 at 4:25

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 9 1946 to Apr 17 1946 1946and that I last saw her alive on Apr 16 1946 1946

## Immediate cause of death

Pneumonia

DURATION

7 days

Due to

Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

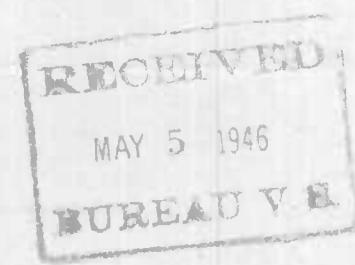
## Means of injury

## Injured at work?

## 23. SIGNATURE

M. D. or other

Address: Maurice Hudson Date signed Apr 19



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5th

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County

Wisconsin

City or town

Salisbury R. D. 3

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

51 years

Hospital, Institution, or street address where death occurred:

Belmar Blvd. R. D. 3.

How long in hospital or institution?

## 3. (a) FULL NAME

Edgar S. Parker

4. Sex

5. Color of eyes

6. (a) Single, married, widowed, or divorced

Male

white married

6. (b) Name of husband or wife

Lillie M. Parker

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age 43 years

March 26, 1891

8. AGE:

Years

Months

Days

Less than one day

51 0 21 hrs. min.

9. Birthplace

Wisconsin Co., Md

(Town, county, and state)

10. Usual occupation

Retail Service Station

11. Industry or business

Filling Station &amp; Store

W. Parker

12. Name

MOTHER FATHER

Wisconsin Co., Md

13. Birthplace

Sarah Ann Parker

14. Maiden name

Wisconsin Co., Md

15. Birthplace

Mrs. Edgar S. Parker

16. Informant

Address

Salisbury Md., R. D. 3.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 4/23/46

(month) (day) (year)

Cemetery or crematory

Persons Cemetery

Location

Salisbury, Md.

18. Funeral director

The Hill Johnson Co.

Address

Salisbury Md.

19. (Date rec'd by registrar)

4/23/46 to April 23, 1946

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Wisconsin

City or town

Salisbury R. D. 3

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 20, 1946, at 4:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1, 1946, to April 20, 1946, and that I last saw him alive on April 20, 1946.

Immediate cause of death

Carcinoma of Prostate  
with metastases.

DURATION

9

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

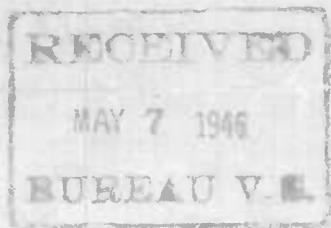
John H. Jameson M.D.

M. D. or other

Address

338 Camden Ave., John 100.

Date signed April 23, 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

## CERTIFICATE OF DEATH

04197  
Reg. Dist. No. 333M  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

9-45

VS A15

## 1. PLACE OF DEATH:

County... Wicomico  
City or town... Powellville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Margie Virginia Perdue4. Sex Female Color or race White 5. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife J. William Perdue7. Birth date of deceased (mo., day, yr.) Jan. 22, 1891 6. (c) If alive, give age 66 years8. AGE: Years 55 Months 2 Days 18 If less than one day hrs. min.9. Birthplace Powellville, Wic. Md. (Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Eli T. Jones13. Birthplace Whitewater, Md.14. Maiden name Leah Nancy Adams15. Birthplace Powellville, Md.16. Informant Mr. J. W. PerdueAddress Powellville, Md.17. Burial Buried Date thereof 4/13/46 (month) (day) (year)Cemetery or crematory JonesLocation Powellville, Md.18. Funeral director Dunn & BurdetteAddress Berlin, Md.19. Date received by registrar 4/13/46 19. H. G. Bassett, Jr. Johnson  
(Date received by registrar) (Signature) (Registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WicomicoCity or town... Powellville (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

April 10, 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 19, 1946 to April 10, 1946 and that I last saw her alive on April 7, 1946

## Immediate cause of death

CA of Intemperance

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

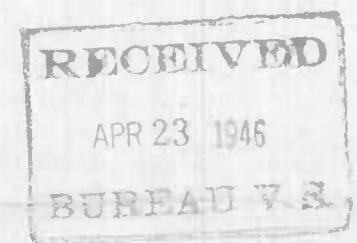
Means of injury ..... Injured at work?

## 23. SIGNATURE

John H. Gray, M.D.

M. D. or other

Address... Salisbury, Md. Date signed 4/13/46



Evidence for addition of approximate age of deceased is shown on

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

04198

FILM No. I 01 APR 29 1946

Reg. Dist. No. 71336

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Male Black

5. Color or race

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 7 Months 50 Days 2 It less than one day Approx. - 7 50 2 2 hrs. min.

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Cemetery or crematory

Location

18. Funeral director

Address

19. 4-15-1946 (Date rec'd by registrar)

20. Usual residence (HOME) of deceased (For newborn infants give residence of mother)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Virginia

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

W. East 80 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

4/15/46 1946 at 7:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. medicine to die on 4/15/46 at 7:45 a.m. Baltimore 1946

Immediate cause of death

Seizure of entire body

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

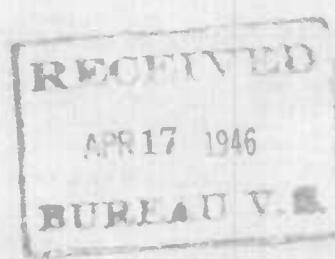
None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4/15/46Where did injury occur? Baltimore (City or town) area (County) area (State)Injured at home, farm, Industry, public place (where?) NoneMeans of injury shock cough Injured at work? Nofire fall down no23. SIGNATURE Deputy Med. Examiner M. D. or otherAddress Baltimore Date signed 4/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 113

04199

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico

City or town Near Pittsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

12. Woods, Near Pittsville

How long in hospital or institution? Not.

## 3. (a) FULL NAME

Rosenberg, Arnold F

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

23 Nov., 1924

8. AGE:

Years

21

Months

4

Days

22

11 less than one day

hrs.

min.

9. Birthplace

Massachusetts

(Town, county, and state)

10. Usual occupation

Pilot - U.S. Army

11. Industry or business

Benedict Bernard

12. Name

MOTHER

FATHER

Russia

13. Birthplace

MOTHER

FATHER

14. Maiden name

MOTHER

FATHER

15. Birthplace

MOTHER

FATHER

16. Informant

MOTHER

FATHER

17. Burial

MOTHER

FATHER

18. Funeral director

MOTHER

FATHER

19. Address

MOTHER

FATHER

19. Date rec'd by registrar

MOTHER

FATHER

19. Date signed

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County Kent

City or town Dover (If outside city or town limits, write RURAL and give nearest town)

Street No. Dover Army Air Base Field (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 15 April

approx. 1946 at 1030 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Decatual Examination Report 19

and that I last saw h... m... alive on

Immediate cause of death Dismemberment and Disembowelment

DURATION

Due to Violent Contact with metal parts of Aircraft.

Due to Aircraft crashing into trees and ground.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

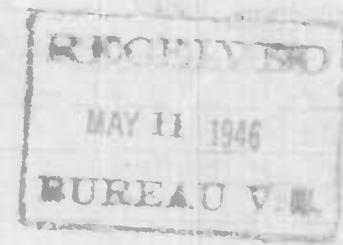
Accident, suicide, or homicide Aircraft Accident Date of 14 APRIL 46

Where did injury occur (Near) Pittsville (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) In Woods

Means of injury Aircraft Accident injured at work? Yes

23. SIGNATURE *Class Fisher* M.D. or otherAddress *Bellevue Hospital* Date signed *4/14/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1570

04200

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 13 days

## 3. (a) FULL NAME

Valerie Carol Sample

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white

Single

B. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 6, 1946

8. AGE: Years

Months

Days

If less than one day

13

hrs.

min.

9. Birthplace

Salisbury, Wic.

Md.

(Town, county, and state)

10. Usual occupation

infant

11. Industry or business

John Sample

FATHER

12. Name

John Sample

MOTHER

13. Birthplace

Delmar, Del.

14. Maiden name

Esther Davis

15. Birthplace

Wilmington, Del.

16. Informant

John Sample

Address

Delmar, Del.

17. (Burial, cremation, or removal) Where

Burial 4-20-46

Date thereof

(month)

(day)

(year)

Cemetery or crematory

Location

Delmar, Del.

18. Funeral director

W.S. Harrel Co.

Address

Delmar, Delaware

19. (Date rec'd by registrar)

4/20/46

1946

H. 200

1946

Signed: John Sample  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No. 304 Maryland Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

APRIL 18 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8 April 1946 to 18 April 1946

and that I last saw her alive on 18 April 1946

Immediate cause of death Congenital

Meconium Aspiration

Due to Spina Bifida

Due to

Other conditions Multiple Congenital

defects

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John Sample M.D.

M. D. or other

Address

Delmar, Maryland

Date signed

19 April 1946

RECEIVED

MAY 7 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

04201

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *McComis*  
 County: *Salisbury* 13 yr  
 City or town: *(If outside city or town limits, write RURAL and give nearest town)*  
 How long in above place of death: *639 W. Main St.*  
 Hospital institution or street address where death occurred: *639 W. Main St.*  
 How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: *Md.* County: *McComis*  
 City or town: *Salisbury* *If outside city or town limits, write RURAL and give nearest town)*  
 Street No: *639 W. Main St.* *If rural, give LOCATION)*

3. (a) FULL NAME *Annie E. Savage*

3. (b) Social Security Number

4. SEX: *Female* 5. Color or age: *White* 6. (a) Single, married, widowed, or divorced: *Widow*

6. (b) Name of husband or wife: *Deaf*

7. Birth date of deceased (mo., day, yr.): *Oct. 5-1848* 6. (c) If alive, give age: *104* years

8. AGE: *97* Years *5* Months *26* Days If less than one day:  hrs.  min.

9. Birthplace: *Sussex Co. Del.* (Town, county, and state)

10. Usual occupation: *at home*

11. Industry or business: *Peter Society*

12. Name: *Peter Society*

13. Birthplace: *Sussex Co. Del.*

14. Maiden name: *Rebecca Collins*

15. Birthplace: *Sussex Co. Del.*

16. Informant: *John Savage*

Address: *639 W. Main St. Salisbury Md.*

17. Burial: *Burial* Date thereof: *April 4/46* (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: *Cokerbury Cem.*

Location: *near Georgetown Del.*

18. Funeral director: *John J. Carey*

Address: *Georgetown Delaware*

19. (Date rec'd by registrar) *4/4/46* 1946 Hospital of Johnson & Johnson, Inc. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *April 1 1946* at *9 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *April 1 1946* to *April 1 1946* death and that I last saw her alive on *April 1 1946*.

Immediate cause of death: *Cardiac Decompenation*

Due to: *Arteriosclerotic e-v-r disease*

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide:  Date of:

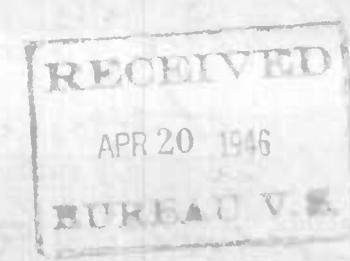
Where did injury occur?  (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury:  Injured at work?

23. SIGNATURE: *John J. Carey* M. D. or other

Address: *Georgetown Delaware* Date signed: *4/2/46*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04202

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

## 1. PLACE OF DEATH:

County WisconsinCity or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

421 Carlton Ave

How long in hospital or institution?

## 3. (a) FULL NAME

Henry Schroeder

4. Sex

5. Color or race

(Ex) Single, married, widowed, or divorced

Male white Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

Aug. 10, 1870

8. AGE:

Years 75 Months 8 Days 4 If less than one day

hrs.

min.

9. Birthplace

New York City  
(town, county, and state)

10. Usual occupation

Accountant

11. Industry or business

Retired

MOTHER FATHER

12. Name Conrad Schröder

13. Birthplace

Germany

14. Maiden name

Not known

15. Birthplace

Philadelphia

Address

421 Carlton Ave Salisbury, Md

17. Burial

Date thereof 4/15/1946  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Parson Cemetery

Location

Salisbury, Md

18. Funeral director

The White Johnson Co.

Address

Salisbury, Md

19. (Date rec'd by registrar)

4/20/1946

1946

1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty WisconsinCity or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 421 Carlton Ave

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 14

1946

at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 10 1946 to April 14 1946and that I last saw him alive on April 14 1946

Immediate cause of death

UremiaDue to Butterosilvite C-V-RDiseaseDue to Prostatectomy, perhaps

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John Department

M. D. or other

Address

Salisbury, Md

Date signed

RECEIVED

MAY 7 1946

BUREAU V R

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04203

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

1. PLACE OF DEATH: *McComis*  
 County: *Salisbury*

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex: *Male* 5. Color or race: *White* 6. (a) Single, married, widowed, or divorced: *Married*

8. (b) Name of husband or wife: *Marie S. Laverne Shockley*

7. Birth date of deceased (mo., day, yr.): *Feb. 6<sup>th</sup> 1870* If alive, give age: *74* years

8. AGE: *76* Years *2* Months *10* Days If less than one day: *hrs.* *min.*

9. Birthplace: *R.D. Parsonsburg Md.* (Town, county, and state)

10. Usual occupation: *Retired*

11. Industry or business: *Retired*

12. Name: *Benjaleah Shockley*

13. Birthplace: *R.D. Parsonsburg Md.*

14. Maiden name: *Hammond*

15. Birthplace: *R.D. Parsonsburg Md.*

16. Informant: *Mrs. Martha B. Shockley*

Address: *314, Smith St. Salisbury Md.*

17. Burial: *Burial* Date thereof: *April 18-46* (Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory: *Hammond Cem.*

Location: *R.D. Salisbury Maryland*

18. Funeral director: *Hollingsworth & Co. Walter P. Hollingsworth*

Address: *Salisbury Maryland*

19. *4/17/46* (Date rec'd by registrar) *Death* *J. L. Johnson* (Signature of Registrar) *Registrar*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: *Md.* County: *Salisbury*

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. *919 Railroad Ave* (If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *April 16<sup>th</sup> 46* at *9:30*

21. CERTIFY that death occurred on the date above stated; that I attended deceased from *April 1* to *April 16*

and that I last saw her alive on *April 16* at *9:30*

Immediate cause of death: *Chronic Myocarditis.*

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_

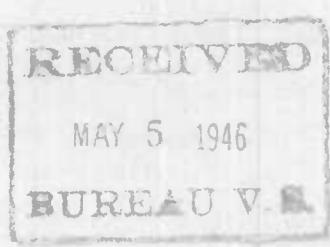
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

At home, farm, Industry, public place (where?) \_\_\_\_\_

Means of injury: \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE: *J. L. Grammer, M.D.* M. D. or other

Address: *Salisbury Maryland* Date signed: *4/17/46*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04204 336

## CERTIFICATE OF DEATH

Reg. Dist. No. *4*

## 1. PLACE OF DEATH:

County *Wicomico*City or town *Delmar*

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

*P 710 # 3*

Stay in hospital or Inst. (yrs., or mos., or days)

*82 yrs.*

## 3. (a) FULL NAME

*Elizab. Quinton Sturgis*4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Sinda Sturgis* 6. (c) If alive, give age *70* years7. Birth date of deceased (mo., day, yr.) *Oct 9 1863*8. AGE: Years *82* Months  Days  If less than one day  hrs.  min. 9. Birthplace *Wicomico County, Md.* (Town, county, and state)10. Usual occupation *Farmer*11. Industry or business *Farm*12. Name *Chas. H. Sturgis*13. Birthplace *Wicomico County, Md.*14. Maiden name *Mary E. Parsons*15. Birthplace *Wicomico County, Md.*16. Informant *Ira James Sturgis*Address *Delmar, Md.*17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *4-10-46* (month) (day) (year)Cemetery or crematory *Delmar*Location *Delmar, Md.*18. Funeral director *J. S. Grand Co*Address *Delmar, Md.*19. (Date rec'd by registrar) *April 10, 1946* (Date signed) *Harry E. Hudson* (Registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Wicomico*City or town *Delmar* Ward No. 

(If outside city or town limits, write RURAL NEAR and give town)

Street No. *P 710 # 3*

(If rural give LOCATION)

## 2(a) IF VETERAN, NAME WAR

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *April 7 1946*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Nov. 1945, to April 7 1946*, and that I last saw him alive on *April 6 1946*Immediate cause of death *acute dilatation of heart* DURATION *four months*Due to *Chronic myocarthritis* *5 yrs.*Due to *Chronic nephritis* *3 yrs.*

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings:

Of operations

Of autopsy

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, Industry, public place (where?)

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE *J. H. Lynch*M. D. or other *Physician*Address *Delmar, Md.* Date signed *Apr 8/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

## CERTIFICATE OF DEATH

04205

Reg. Date. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

105 Cherry St.

How long in hospital or institution?

3. (a) FULL NAME

Gordon B. Townsend4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widower6. (b) Name of husband or wife Maggie Townsend7. Birth date of deceased (mo., day, yr.) April 1, 1871 6. (c) If alive, give age years8. AGE: 75 Years 0 Months 0 Days 0 If less than one day 0 hrs. 0 min.9. Birthplace Unknown (Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name Preston Townsend13. Birthplace Unknown14. Maiden name Marcissa Jones15. Birthplace Unknown16. Informant Elmer HolstonAddress Newark, Md17. Burial Funeral Date thereof April 22, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Olney CemeteryLocation Worcester Co., Md18. Funeral director Charles WashellAddress Princess Anne, Md.19. 4/21/46 19 4/21/46 Charles D. Johnson Registrar  
(Date rec'd by registrar) (Date signed) (Signature) (Title)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Cast Princess Anne, Md  
(If outside city or town limits, write RURAL and give nearest town)Street No.   
(If rural, give LOCATION)2. (a) If veteran, name war 

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 19 46 at 6:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-1-46 to 4/20 19 46and that I last saw him alive on 4-20 19 46Immediate cause of death arteriosclerotic nephritis

DURATION

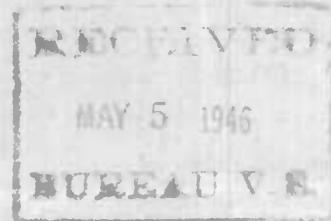
6 hrsDue to ObesityDue to Other conditions 

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 25Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE Elmer Holston M. D. or other MDAddress Salisbury, Md Date signed 4/21/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

04206

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH

County

City or town

Hancock Co.  
Pittsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Main street

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White married  
Elizabeth Truitt

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

## 11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date read by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Main street

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

August 1945 19 to day of death 19

and that I last saw him alive on

day of death 19

Immediate cause of death

Myocarditis classic

Due to

Due to

Other conditions

Hypertension  
Cerebral sclerosis

DURATION

2 yrs

Major findings of operations

Date of op.

Anterior results

HYGIENIC: Please underline the cause to which death should be charged statistically.

21. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Cause of injury

Injured at work?

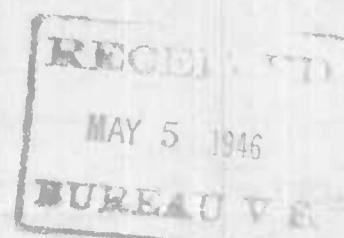
## 23. SIGNATURE

Frank A. Lewis M.D.

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46B

## CERTIFICATE OF DEATH

04207  
Reg. Dist. No. 339

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Pen. Gen. Hosp.

How long in hospital or institution? 16 days 22 hrs. 5 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1708 N. Division

(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

4. Sex

5. Color of face

6. (a) Single, married, widowed, or divorced

female

White

Married

8. (b) Name of husband or wife

Howard P. Waller

61

7. Birth date of deceased (mo., day, yr.)

Feb. 15<sup>th</sup> 1888

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

58

1

25

hrs. min.

9. Birthplace

Somerset Co. Maryland

(Town, county, and state)

10. Usual occupation

House wife

at home

11. Industry or business

Thomas H. Heath

MOTHER FATHER

Movie Maryland

12. Name

Louise Anna Frances Murphy

13. Birthplace

Tyrone, Maryland

14. Maiden name

Howard P. Waller

15. Birthplace

Tyrone, Maryland

16. Informant

Mr. Howard P. Waller

17. Burial

1708 N. Division, Salisbury, Md.

(Burial, cremation, or removal. Which?)

Date thereof (month) (year)

Cemetery or crematory

Alcorn's Cemetery, Park

18. Location

Salisbury, Maryland

19. Funeral director

Holloway &amp; C. Waller P. Holloway

Address

Salisbury, Maryland

20. (Date rec'd by registrar)

1946

1946

Death to Johnson

Local Registrar

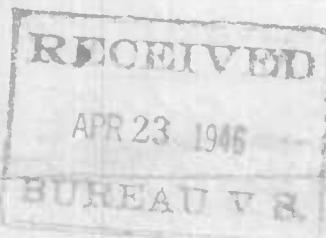
## 23. SIGNATURE

M. D. or other

Address

Date signed

4/12/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

## CERTIFICATE OF DEATH

14208

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County

Wisconsin

City or town

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

31 years

Hospital, institution, or street, address where death occurred:

306 Hazel Lane

How long in hospital or institution?

## 3. (a) FULL NAME

Bertha May Washburn

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white married

Louis F. Washburn

7. Birth date of

deceased (mo., day, yr.)

July 11, 1876

6. (c) If alive, give age .....

years

8. AGE:

Years

Months

Days

If less than one day

69

9

17

hrs.

min.

9. Birthplace

Wisconsin or Md.

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

MOTHER FATHER

Lester Fields

MOTHER

13. Birthplace

Wisconsin or Md.

FATHER

14. Maiden name

Catherine A. Stewart

15. Birthplace

Wisconsin or Md.

16. Informant

Mo Franklin Washburn

Address

Salisbury, Md.

17. Burial

Date thereof: 5/11/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Shad Point Cemetery

Location

Shad Point Md.

18. Funeral director

The Hill &amp; Johnson

Address

Salisbury, Md.

19. (Date rec'd by registrar)

19. (Date signed by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Wisconsin

City or town

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

306 Hazel Lane

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 28, 1946, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 24, 1946, April 28, 1946

and that I last saw her alive on April 28, 1946

Immediate cause of death: Valvular Heart Disease, 5 years (duration)

Due to:

Due to:

Other conditions:

Hyperthyroidism

(Include pregnancy within 8 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..

Date of .....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

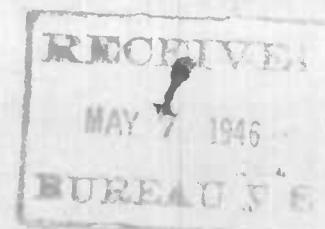
23. SIGNATURE

Katherine R. Mann

M. D. or other

Address

Salisbury, Md. Date signed



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B10*

## CERTIFICATE OF DEATH

04209

Reg. Dist. No. 11

## 1. PLACE OF DEATH:

County *Wilmington*City or town *Delmarva Rd Side*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death *Twenty five years*Hospital, institution, or street address where death occurred: *no*How long in hospital or institution? *no*

## 3. (a) FULL NAME

*Beatrice A West*4. Sex *Female*5. Color or race *A.A.*6. (a) Single, married, widowed, or divorced *Widow*6. (b) Name of husband or wife *James A West*7. Birth date of deceased (mo., day, yr.) *60 Dec*6. (c) If alive, give age *no* years8. AGE: Years *about 58*

Months

Days

If less than one day

hrs. *min.*9. Birthplace *Laurel Del*

(Town, county, and state)

10. Usual occupation *Housewife*11. Industry or business *same as above*12. Name *Henry West*13. Birthplace *Laurel Del*14. Maiden name *Conley*15. Birthplace *Laurel Del*16. Informant *Franklin M. West*Address *Delmar Md Side*17. Burial *Burial*

(Burial, cremation, or removal. Which?)

Date thereof *Apr 11 1946*  
(month) (day) (year)Cemetery or crematory *Union*Location *Delmar Rd Side*18. Funeral director *James A. Stewart*Address *Salisbury Md*19. Date rec'd by registrar *April 11 1946*

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Del*County *Wilmington*City or town *Delmar Md*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *no*

(If rural, give LOCATION)

2.(a) If veteran, name war *no*

## 3. (b) Social Security Number

*no*

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

*April 8, 1946 at 1:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*July 1944 to April 8, 1946*  
and that I last saw her *alive on March 27, 1946*Immediate cause of death *Chronic Myocarditis*Due to *Hypertension*Due to *Chronic Nephritis*Other conditions *no*

(Include pregnancy within 3 months of death)

Major findings or operations *no*Date of op. *no*Autopsy results *no*

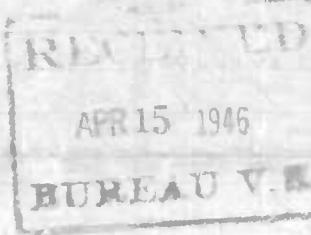
PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *no*Date of *no*Where did injury occur? *no*(City or town) *no*(County) *no*(State) *no*Injured at home, farm, industry, public place (where?) *no*Means of injury *no*Injured at work? *no*

## 23. SIGNATURE

Address *Salisbury Md*A. D. or Other *no*Date signed *4/11/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Kuhlman

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

04210

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Pensacola General Hospital  
1 hr. 55 mins.

How long in hospital or institution?

## 3. (a) FULL NAME

Wheatley M. House

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male W Mollie E. Wheatley

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age years

Aug 12 1869

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

Jessie R. WheatleyMarine Engineer

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19. (Date signed)

20. Date of death

Date thereof

(month)

(day)

(year)

Date signed

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Dorchester

City or town Galestown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

214-16-41061

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr 8 1946 at 2:55 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 8 1946 to Apr 9 1946 and that I last saw him alive on Apr 9 1946.

Immediate cause of death

Secondary Occlusion.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. S. Kuhlman M. D. or otherAddress Sharpstown Rd Date signed 4/10/46

RECEIVED

APR 23 1946

BUREAU V.P.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

04211

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County.....

Salisbury

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

23 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

E. J. Has. Williams

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

Male

Col.

Married

6. (b) Name of husband or wife.....

A. M. Williams

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age.....

58

years

Mar. 15, 1885

8. AGE: Years

Months

Days

If less than one day

61 28 hrs. min.

9. Birthplace.....

Fruitland Md

(Town, county, and state)

10. Usual occupation.....

Labor

11. Industry or business.....

For Ginsburg Seabase

FATHER

12. Name.....

J. E. Williams

13. Birthplace.....

Md

14. Maiden name.....

Don't know

15. Birthplace.....

Md

16. Informant.....

A. M. Williams

Address.....

130 David St. Salisbury

17. (Burial, cremation, or removal. Which?)

Burial Date thereof..... April 14, 1946

(month)

(day)

(year)

Cemetery or crematory.....

Bonston Cem. Salisbury

Location.....

Salisbury, Md.

18. Funeral director.....

E. J. Has. Williams

Address.....

Divide, Md

19. (Date rec'd by registrar)

19. 4/14/46

(Date rec'd by registrar)

19. 4/14/46

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Wicomico

City or town.....

Salisbury, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

130 David St.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH.....

April 10 1946 at 11 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

16 Feb

1946 to 10 April 1946

and that I last saw him alive on 10 April 1946

Immediate cause of death.....

Malignancy of Stomach

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

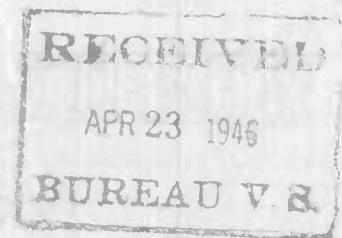
Arthur D. Browne, M.D.

M. D. or other

Address.....

Salisbury, Md

Date signed 4/14/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

180

64212

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WilmotnoCity or town Salisbury MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred

8. Seven HospitalHow long in hospital or institution? no

## 3. (a) FULL NAME

William Wright

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male a a Married6. (b) Name of husband or wife Helen WrightWife Don't know

7. Birth date of deceased (mo. day, yr.)

8. (c) If alive, give age years1905

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

409. Birthplace Wetiflawn MD

(Town, county, and state)

10. Usual occupation Wilmotno11. Industry or business Same as above

FATHER

12. Name Anthony Wright13. Birthplace Wetiflawn MD14. Maiden name Elizabeth Leach15. Birthplace Salisbury MD16. Informant Edward Leach

Address

Salisbury MD

17. Burial

(Burial, cremation, or removal (which))

Date thereof Apr 18 46

(month) (day) (year)

Cemetery or crematory

Oak Bluffs

Location

Wetiflawn MD

18. Funeral director

James P. Stewart

Address

Salisbury MD

19. (Date rec'd by registrar)

4/15/46

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD

County

WilmotnoCity or town Salisbury MD

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

na

2. (a) If veteran, name war

## 3. (b) Social Security Number

216-14-2646

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 46 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/12 1946 to 4/13 1946and that I last saw him alive on 4/12 1946

Immediate cause of death

Burns of body

DURATION

8 hoursDue to Brush fire

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4/12 46Where did injury occur near Salisbury (City or town) (County) (State) WicomicoInjured at home, farm, industry, public place (where) homeMeans of Injury BurnsInjured at work? Yes23. SIGNATURE Oliver Fisher M.D.

Deputy medical Examiner M. D. or other

Address Salisbury MD Date signed

